



AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT

Insured's Name: _____

DBA: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone #: _____ Other Phone #: _____

.....
DIRECT Payment Plan Instructions:

1. Attach a voided check.
2. The number of installments _____.
3. The amount of each payment is \$ _____. Select will debit each payment monthly on your due date. (If the due date falls on a holiday or weekend, payment will be drafted on the next business day.)
4. Don't forget to update your records on a monthly basis.

Cancellation of Direct Payment Plans: Select Premium must be notified in writing within 5 business days of your next due date. Any direct debit returned not honored by the bank will be assessed a \$15.00 return debit fee and will result in the Direct Payment Plan to be voided immediately!

.....
Insured's Signature: _____ Date: _____

Print Name: _____

Must have original document and voided check prior to withdrawal date!!
We Appreciated Your Business!

Tape Voided Check Here

